WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Instructions
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, HCF 11092. Pharmacy providers (e.g., pharmacies, dispensing physicians, federally qualified health centers, blood banks) are required to use the PA/PDL for Growth Hormone Drugs form to request PA by using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA/PDL forms in one of the following ways:

1) For STAT-PA requests, pharmacy providers should call (800) 947-1197 or (608) 221-2096.

2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), HCF 11018, and the PA/PDL form by fax to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the PA/PDL form to the following address:

   Wisconsin Medicaid
   Prior Authorization
   Ste 88
   6406 Bridge Rd
   Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Enter the drug name.

Element 5 — Strength
Enter the strength of the drug listed in Element 4.

Element 6 — Date Prescription Written
Enter the date the prescription was written.

Element 7 — Directions for Use
Enter the directions for use of the drug.

Element 8 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

Element 9 — Name — Prescriber
Enter the name of the prescriber.

Element 10 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 11 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

Element 13 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 14 — Date Signed
Enter the month, day, and year the PA/PDL for Growth Hormone Drugs form was signed (in MM/DD/YYYY format).

SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS
Include diagnostic and clinical information explaining the need for the drug requested. In Elements 15 through 21, check "yes" to all that apply.

Element 15
Has the recipient tried and failed a preferred growth hormone drug? Preferred growth hormone drugs include Norditropin, Nutropin AQ, Saizen, and Tev-Tropin.

Element 16
Check the box to indicate whether or not the recipient's chronological age is under 20 years.

Element 17
Check the box to indicate whether or not the recipient's skeletal age is documented to be under 18 years.

Element 18
Check the box to indicate whether or not the prescription was written by an endocrinologist. The prescription must be written by an endocrinologist for the recipient to begin treatment with a growth hormone drug.

Element 19
Check the box to indicate whether or not the recipient has a diagnosis of growth deficiency. The recipient must have a diagnosis of growth deficiency to begin treatment with a growth hormone drug.

Element 20
Check the box to indicate whether or not the recipient has a diagnosis of Prader Willi or Turner's Syndrome. If the recipient has a diagnosis of Prader Willi or Turner's Syndrome, a stimulated growth hormone test is **not** required.

Element 21
Check the box to indicate whether or not the recipient had a recent stimulated growth hormone test that demonstrated a clear abnormality. Indicate the test result and normal range.

SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA
In Elements 22 through 25, prescribers should indicate "1" if the response to the question is yes. Indicate "2" if the response is no.

Element 22 — Diagnosis
The recipient must be at least 18 years of age and have a diagnosis of Human Immunodeficiency Virus (HIV) to begin treatment with a growth hormone drug.

Element 23 — Recipient's Current Medical Condition
Indicate the recipient's current medical condition by responding to the clinical information listed in this section.

Element 24 — Evidence of Wasting Syndrome
The recipient must have either an unintentional weight loss of at least 10 percent or a gastrointestinal (GI) obstruction or malabsorption to qualify for treatment with a growth hormone drug.

Element 25
All of the clinical information listed must be tried and failed before a recipient may begin a course of therapy with a growth hormone drug.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 26 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 27 — Days' Supply Requested
Enter the requested days' supply.

Element 28 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 29 — Date of Service
Enter the requested first date of service (DOS) for the drug in MM/DD/YYYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 30 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
00	Not Specified
01	Home
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Element 31 — Assigned Prior Authorization Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 32 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 33 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 34 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

Element 35
Check the box to indicate if additional information is necessary. Submit additional information on a separate sheet.